TO: Members: Governor's Task Force on Information Technology In Health Care

FROM: Governor.Ehealth

SUBJECT: Weekly Communiqué

DATE: August 4, 2005

COMMUNICATON BULLETIN

Thanks for utilizing the email at governor.ehealth@vdh.virginia.gov. This email is monitored daily and can also accommodate special communication requests.

Web site update: The Governors Task Force web site is in production at http://www.ehealth.vi.virginia.gov/.

FEDERAL ACTIVITIES

The following federal update has been provided by the VHHA.

Johnson Introduces Bill To Link Medicare Physician Reimbursements to Quality of Care
[Jul 29, 2005]

House Ways and Means Health Subcommittee Chair Nancy Johnson (R-Conn.) on Thursday introduced a bill that would repeal the existing formula for calculating Medicare's physician payments and replace it with a system linking payments to quality, CongressDaily reports. The measure, which seeks to preempt a scheduled 4.3% cut in Medicare physician payments in January, could become part of this fall's budget reconciliation package, according to Johnson (CongressDaily, 7/28). At a press briefing to announce the introduction of her bill, Johnson said it is "extremely important" that Congress not continue to "kick the can down the road" by enacting a temporary payment fix to avoid the scheduled cut, as it has done in years past. The $30 billion to $40 billion cost of such fixes should go toward a permanent change in the Medicare doctor payment system, Johnson said. Her proposal would eliminate the existing sustainable growth rate formula and replace it with a system under which annual payment increases would be based on the growth of the Medical Economic Index. MEI tracks the cost of providing physician care. The bill calls for a 1.5% payment increase in 2006. MEI-based payment increases, which would start in 2007, would be reduced by one percent that year and in 2008 if doctors fail to report data on the quality of care they provide. According to CQ HealthBeat, the legislation does not include "gainsharing" provisions, which allow doctors and hospitals share savings if they develop ways to improve the efficiency of treatments (CQ HealthBeat [1], 7/28).

Costs, Outlook
The Congressional Budget Office has estimated that repealing the current SGR formula would cost as much as $183 billion over the next 10 years (CongressDaily, 7/28). CBO also has estimated that an MEI-based system would cost as much as $155 billion over 10 years. Johnson and House Ways and Means Committee Chair Bill Thomas (R-Calif.) have called on CMS to administratively remove prescription drug spending from the physician payment formula, which would reduce the 10-year cost of an MEI-based system by $114 billion. CMS officials have said they might not have the legal authority to make such a change. According to CQ HealthBeat, it is "unclear" how much support Johnson has for her bill. Thomas has yet to announce his support, but Johnson says he is "supportive" of her efforts (CQ HealthBeat [1], 7/28). C. Anderson Hedberg, president of the American College of Surgeons, at the conference said that the group would not support a quality-improvement effort unless the threat of payment cuts is eliminated. Meanwhile, CongressDaily reports that the inclusion of Johnson's proposal in the fall's budget reconciliation package "might open other parts of the Medicare program, which the [Bush] administration and GOP leaders want to avoid during the delicate implementation period for Medicare's drug benefit" (CongressDaily, 7/28).

MORE FROM THE FEDERAL SIDE

Cost of Electronic Record Keeping May Soar

By KEVIN FREKING, Associated Press Writer Mon Aug 1, 6:03 PM

CMS's proposal to create a national network of electronic health records could cost more than $200 billion initially to build and operate, researchers said Monday. The health care industry itself, based on current estimates, will cover less than 20 percent of that amount.

"These findings suggest that policy initiatives are needed if we are to close this gap," said a study published in the Annals of Internal Medicine.

The government doesn't necessarily have to come up with the difference, the researchers said.

"I don't see them as having to foot the bill," said the lead author, Dr. Rainu Kaushal. "They can create the incentives. Then the private sector can run with it."

For example, the federal government could increase reimbursements for doctors who use electronic record keeping for their Medicare and Medicaid patients. That could prompt smaller physician groups to make the sizable investment that is often required for computer systems.

In recent years, many in the health care industry have already made the transition from record keeping systems based on paper files to ones based on computers. Experts say the new electronic systems save lives and money.

Members of Congress and the Bush administration, urged on by the health care sector, want to hasten that transition. So researchers tried to project how much it would cost. Their work was jointly funded by the Commonwealth Fund and the Harvard Interfaculty Program for Health Systems Improvement.

The researchers estimated that it would cost $156 billion to build the system and $48 billion annually to run it.

"We know it's expensive," said Dr. David Brailer, appointed by Bush to coordinate the government's efforts for improved health information technology.

"We know it's in the billions of dollars, perhaps in the tens of billions of dollars, and possibly even the hundreds of billions," Brailer said. "But the principle question is not how much it is. It's how do we create incentives to involve the private
sector and prevent the federal government from financing it all. We want it to be market-driven."

The United Kingdom has allocated about $14 billion to build a health information network. Canada has invested about $1.2 billion — an amount the researchers said likely would have to be increased.

Because the United States may make a sizable investment, researchers sought to flesh out the structure of a model system, as well as its costs.

First, the researchers relied on a panel of health care officials to give them minimum standards that a model network must meet. For example, a doctor in Denver should be able to load information into a computer that could subsequently be viewed and updated by a nursing home in Orlando.

The researchers also determined the type of facilities that should have access to the network. Those selected were doctor's offices, hospitals, pharmacies, clinical labs, nursing homes and home health agencies.

Then they projected what it would cost to make the network available to the slew of providers around the country.

A major barrier to widespread implementation of a health information network is that costs are incurred by a few, but the benefits are spread out to the many.

"Institutions tend to invest in areas with direct financial benefits to themselves, such as new equipment or facilities," the authors of the report said. "It seems unlikely that the private sector will move forward rapidly to adopt (information
technology) without public sector investments or incentives."

Brailer noted that the researchers relied on expert estimates — not primary data.

He estimated that the current spending throughout the federal government on health information networks totals about $4 billion a year. He believes the estimate of $156 billion in startup costs and $48 billion in operating costs to be on the high end of what the system would actually total.

Brailer and Kaushal said the investments in electronic record keeping are occurring mostly with large hospital systems.

INTEROPERABILITY

To review the activities of other organizations pursuing electronic exchange, you may wish to visit the MA Health Data Consortium web page at www.mahealthdata.org. This we site contains the monthly publication entitled, MA Health Data Consortium Newsletter.

MEETING NEWS

Workgroup for Electronic Data Interchange (WEDI) is dedicated to improving healthcare through Electronic Commerce. This info regarding a WEDI audiocast is found On: http://www.wedi.org/public/calendar/index.cfm?fuseaction=event&id=938

Title: WEDI Audiocast: How ROI Can Be Achieved Through the Electronic Health Record (EHR)
Date: August 11, 2005

Time: 1:00 PM - 2:30 PM - Eastern
City:
State/Province:
Country: United States
Event Type: Teleconference, Audiocast, SNIP, WEDI,

Description:
Is Electronic Health Record (EHR) ROI a contradiction in terms? Can physician practices gain real efficiencies by implementing this expensive and complex technology? The pressure is increasing for practices and other healthcare institutions to invest in EHR. A growing body of evidence suggests that electronic clinical applications can improve the quality of healthcare, boost patient safety, and increase efficiency and timeliness of care. These potential benefits are fueling the conversion from paper-based medicine to EHRs and driving actions from the federal government. During this 90 minute live broadcast, you will learn from national EHR experts what the real ROI is for these systems, become aware of the latest federal initiatives and how these may impact your organization, and come away with a blueprint on how best to implement these complex technologies. Participants will also have the opportunity to ask questions of the faculty.

Conference Information:
http://www.wedi.org/public/articles/dis_viewArticle.cfm?ID=340
Registration: http://www.regonline.com/26541
Contact: Patti Brown
Phone: (703)391-2717
Email: pbrown@wedi.org

TASK FORCE MEMBER NEWS

Don Detmer, President and CEO of the American Medical Informatics Association testified during a House Ways and Means Committee hearing today on health information technology. The hearing focus was on recent developments and how Congress can encourage further development. Complete testimony from the hearing is available at:
http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=436